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Apolline Kohen
Committee Secretary
Senate Community Affairs Legislation Committee
Sent via email: community.affairs.sen@aph.gov.au

Dear Apolline

***Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026* – ANZCA feedback**

Thank you for the opportunity for the Australian and New Zealand College of Anaesthetists (ANZCA) to provide feedback on the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026*, under the Senate Community Affairs Legislation Committee for inquiry.

Summary feedback

ANZCA, including the Faculty of Pain Medicine (FPM):

- Supports improving fee transparency for patients.
- Is a signatory to the Council of Presidents of Medical College's (CPMC's) "Professional Framework - Ethical Billing and Free Transparency".
- Recommends that published fee information is accompanied by clear methodology, appropriate clinical context, and robust mechanisms for practitioner review and correction.
- Emphasises that anaesthesia clinical practice, and subsequent billing can vary considerably with patient and surgical complexity.
- Emphasises that accurate fee transparency is particularly important for patients with chronic pain syndromes.
- Often defers to the Australian Society of Anaesthetists (ASA) on professional fee matters.
- Concludes that fee transparency is only one part of reform required across the health system.

Detailed feedback

About ANZCA

ANZCA, including FPM is the professional body responsible for the postgraduate training programs of specialist anaesthetists and specialist pain medicine physicians. We are one of the largest medical colleges in Australia and New Zealand with 10,000 members.

A key role of the college is fostering the highest standards of clinical practice, safety and high-quality patient care in anaesthesia, pain medicine and perioperative medicine. We

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do this through our robust training programs, rigorous standards, continuous education, mentoring and supervision of junior doctors, advocacy, and research.

ANZCA public and private practice

Across Australia, based on National Health Workforce Data, we know that more than a quarter of anaesthetists and half of specialist pain medicine physicians (SPMPs) work in private settings (with the SPMPs working at multidisciplinary pain clinics or centres).

Training of specialists is a core function of the college and faculty, which provides education, mentoring, and supervision of junior doctors by mostly volunteer specialist anaesthetists and SPMPs. The college and our specialists also provide a significant amount of safety and quality oversight in the health system through the development of professional documents and standards of practice. These elements are heavily relied upon by the Australian health system.

Training of specialists is usually conducted in public teaching hospital settings, however specialist training in private hospitals is increasingly common, supported by initiatives like the Australian government's Specialist Training Program (STP) to provide trainees with experience in diverse healthcare settings beyond traditional public teaching hospitals.

This allows for a broader range of cases (sometimes to satisfy volumes of practice requirements), taps into hospital list capacity and provides exposure to different management styles, contributing to a more skilled and better distributed specialist workforce.

Training can take various forms, such as rotations into private hospitals or placements that are entirely within private facilities. Although these functions do not directly dictate or impact pricing or costing aspects, they do impact private hospital decision-making and partnerships between public and private hospitals.

Supportive with consideration of unintended consequences

ANZCA does not set or regulate professional fees and often defers to the Australian Society of Anaesthetists (ASA) on professional fee matters. However, improving patient safety and experience, providing access to equitable specialist care, as well as workforce wellbeing are relevant to this matter and are very much within the college's remit and role.

ANZCA agrees with the concept of fee transparency in achieving the goals of benefitting the community and informed financial consent for patients and was a signatory to CPMC's "Professional Framework - Ethical Billing and Free Transparency".

From an FPM perspective, initiatives that improve transparency and informed financial consent are particularly important. Many patients with chronic pain delay or avoid specialist care due to uncertainty about out-of-pocket costs. Clearer, reliable information can support earlier engagement and more effective care planning.

However, there are concerns about how the current proposed legislation would be implemented which may have unintended consequences. This includes:

- The misrepresentation of complex procedures.
- Potential to distort market behaviour via some doctors perhaps charging more once they see their colleagues charging higher rates.
- Producing misleading comparisons between surgeons via the persistent perception that higher price equals better quality.
- It uses retrospective averages, not prospective consent - i.e. data are drawn from Medicare, hospital and insurer billing is backward looking. It does not reliably

predict individual out of pocket costs at the point when informed financial consent is actually required.

- In pain medicine, consultation time, patient complexity, comorbidity and models of care vary considerably. A single derived annual fee figure for an individual practitioner is unlikely to accurately reflect the cost of managing complex pain patients and may create misleading comparisons between practitioners or services.
- Clinician fees are exposed in detail, while insurer benefit design, exclusions, rebates and profit margins remain far less visible to patients, perpetuating asymmetric accountability.
- There is risk of reputational harm and perverse incentives. For example, public league table effects may discourage specialists from undertaking high risk, complex or after-hours work, or push pricing toward homogenised “safe” averages rather than value-based care.
- Given the reliance on linked Medicare, hospital and insurer datasets, it is essential that clinicians/colleges have clear and transparent processes to review, validate and request correction of any information published about them. Errors or misattribution of fee data may have significant reputational implications and undermine confidence in the system.

It is also important to remember that not all specialists determine the fees their patients pay. Many specialists work as employees of public or private hospitals, and a growing proportion work within large private practice groups or corporate entities where fees are set organisationally rather than by the individual doctor.

Distinguishing anaesthesia costs

Understanding anaesthesia costing and out of pocket expenses can be challenging. Fees can vary due to complexity / complications / duration, even for similar procedures. In addition, anaesthesia complexity is influenced not only by procedural duration, but by patient-specific risk factors such as age, comorbidities, and perioperative safety considerations, which may not be apparent at the time of booking and are independent of the proceduralist’s practice.

Publishing historic billing data risks oversimplifying anaesthesia and perioperative services that are highly context dependent (case mix, acuity, comorbidity, after hours risk, team models) to a “price list”. Raw fee comparisons may mislead patients rather than inform them.

Private surgeons and other proceduralists may refer their patients to one of a number of different anaesthetists for a given procedure on a given day. This may relate to geographic location (hospital), day of week, and availability. It is unclear how an anaesthetist would be linked to a proceduralist for the benefit of informing the patients about fees. For example, one proceduralist may take four hours to do a hysterectomy, where others may take one hour. Will the anaesthetist fee be linked to the respective proceduralist?

In addition, many activities essential to patient safety and quality provided by anaesthetists, including pre-procedure assessment, multidisciplinary consultation, procedural monitoring and post-operative management, are not well captured in fee or rebate structures.

Interpretation of out-of-pocket costs in pain medicine

A critical limitation of the proposed transparency measures is that they risk misrepresenting SPMP services due to structural inequities in Medicare rebates. While the legislation does not explicitly define or mandate publication of “gap” payments, it

enables and intends the publication of derived out-of-pocket costs. These figures will be interpreted by consumers as indicative of practitioner cost, despite being heavily influenced by underlying Medicare rebate structures.

SPMPs provide care to patients with some of the highest levels of clinical complexity in the health system, often requiring prolonged consultations, multidisciplinary coordination, and longitudinal care. However, Medicare rebates available to most SPMPs are substantially lower than those available to other specialist groups managing less complex presentations.

As a result, even where the total fee charged by a pain specialist is comparable to, or lower than, that of other specialists, the patient out-of-pocket cost ("gap") will appear higher due to the lower Medicare contribution. Under a transparency framework that publishes gap payments without appropriate clinical and funding context, this creates a systematic risk that pain specialists will be portrayed as relatively more expensive, when in fact this reflects under-recognition of complexity within the MBS, rather than differences in practitioner behaviour or value of care.

Without explicit adjustment or contextualisation, publication of such data may unintentionally distort patient choice, disincentivise provision of complex care, and exacerbate existing access barriers for patients with chronic pain. Addressing this requires parallel reform of Medicare rebate structures to better align with consultation complexity and multidisciplinary care requirements.

Parallel approaches

There is general acknowledgment that transparency of fees alone will not resolve specialist fee affordability, and that system-level reform is required. The Bill does not address stagnant Medicare rebates or insurer benefit withdrawal, which are primary causes of rising out of pocket costs, public and community capacity or corporatised practice structures. These are responsibilities of multiple stakeholders across the health system.

Without parallel reform of Medicare rebates, insurer benefit design, and perioperative care pathways, it risks confusing patients, distorting clinician behaviour, and failing to deliver meaningful affordability or choice. It also misattributes system cost issues to the clinician by framing poor transparency as specialist non-compliance, despite well documented structural drivers.

The government must ensure that MBS fees are fairer and contemporary when considering transparency in fees. Medicare rebates in recent years have been under indexed. A narrow focus on fees fails to look at the other cost drivers. This should be calculated based on the real-world expenses of running a clinic, including rent, staff, advanced training, the time a doctor provides, and matching inflation.

There would also be benefit in reporting measures of quality healthcare, such as clinical outcomes and wait times for an appointment (doctor level). Transparency is not just about price – which alone does not correlate to quality. Without this, transparency might inadvertently encourage some patients to choose more expensive doctors, wrongly assuming they will get better care (when no information on quality is publicly available).

Specialist fees often reflect significant variation in patient complexity, clinical risk, and time required to deliver safe care, factors that are not visible to patients through price information alone. Transparency of fees, wait times plus outcomes may also enable GPs to refer patients based on value.

Conclusion

Overall, ANZCA and FPM support the objective of improving transparency for patients and encourage the Senate Committee to ensure that any published fee information is

accompanied by clear methodology, appropriate clinical context, and robust mechanisms for practitioner review and correction.

The college welcomes further conversations in relation to this consultation and can be contacted at ceo@anzca.edu.au.

Yours sincerely

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